STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085048	A. BUILDING _____ B. WING _____	07/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION CAPITOL	1225 WALKER ROAD DOVER, DE 19901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Revised report following IDR request. Desk review for the IDR completed on 9/26/12. Scope and severity of F315 changed from a G to a D. Text changes made to F315. An unannounced annual survey was conducted at this facility from June 26, 2012 through July 3, 2012. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 111. The Stage 2 sample totaled 40 residents.	F 000		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation during the dining observation on 6/26/12, it was determined that the facility failed to promote care for residents in a manner and in an environment that maintained or enhanced each resident's dignity and respect for six residents. Findings include: 1. On 6/26/12 at 11:40 AM lunch trays were observed being delivered to resident rooms in the Magnolia unit (rehabilitation). E11 (CNA) knocked on room 114's door and entered the room with a lunch tray for 114B and then for 114A without	F 241	1.) The staff is now knocking and requesting permission to enter the Resident's room. 2.) All residents have the potential to be affected by this deficient practice. 3.) (a). The Staff Developer and or designee will in-service the Certified Nursing Assistances, The Licensed Nurses and the NHA on knocking and requesting permission to enter the Resident's room. 4.) (a). The Unit Managers or designee will conduct random weekly rounds to evaluate whether staff are knocking and requesting permission to enter the Resident's room (b). The results of this audit will be forwarded to the QA &A Committee for their review. The QA &A Committee will determine the need for further audits and or action plans	9/18/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 10/2/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 requesting permission to enter. 2. E8 (CNA team leader) was observed knocking on room 102's door with a lunch tray and entering without requesting permission to enter. 3. On 6/29/12 at approximately 3:03 PM, E21 (aide) was observed entering room 119 without knocking. 4. On 6/28/12 at approximately 9 AM, E22 (nurse) was observed entering room 110 without knocking. 5. On 6/29/12 at approximately 11 AM, E1 (Administrator) entered into room 118 without knocking.	F 241		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than	F 278		

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F 278	Continued From page 2 $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that the Minimum Data Set (MDS) assessment accurately reflected the resident's status for four (R187, R5, R19 and R29) out of 40 sampled residents. Findings include: 1. Review of R187's admission MDS assessment dated 1/20/12 documented a height and weight of 65 inches and 174 pounds (#) respectively. Subsequent MDS assessment dated 2/9/12 documented that her weight was 156 # (approximately 18 # loss) and that R187 was on a physician prescribed weight loss regimen. Record review lacked evidence that R187 was on a prescribed weight loss regimen. An interview with E9 (Registered Nurse Assessment Coordinator) on 7/2/12 at approximately 3:30 PM confirmed that R187 was not on a weight loss regimen and the above assessment was incorrectly coded. 2. Review of R5's MDS assessments dated 3/18/12 and 6/12/12 documented "no" to the	F 278	1.) (a). R 187 no longer resides at the center (b). R 5's MDS, section J 1400 was modified on 6/28/12 (c). R 19's MDS was modified on 7/23/12 to reflect frequently incontinent (d). R 29's Quarterly Assessment on 7/2/12 was coded as always incontinent 2.) All Residents having MDS's completed are at risk for this deficient practice 3.) (a.) The RNAC or designee will in-service the MDS assistant on coding in Section H, Section K and Section J. 4.) The RNAC or designee will perform random weekly audits of Section H, Section K and Section J to evaluate whether the MDS is coded accurately. Results of these audits will be forwarded to the QA&A committee for their review. The QA &A Committee will determine the need for further audits and or action plans 9/18/12	

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F 278	Continued From page 3 question in Section J1400, "Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months? (requires physician documentation)." An interview with E9 on 6/28/12 at 3 PM confirmed that the facility incorrectly coded the above and a "yes" should have been coded to the above question since R5 was enrolled in a Medicare hospice program. 3. R19's 14 day MDS, dated 3/28/12, coded the resident as having frequent urinary incontinence. R19 was coded as having occasional urinary incontinence on her 30 day MDS, dated 4/10/12. E9 (RNAC) was interviewed on 7/3/12. She reviewed the applicable ADL (activities of daily living) tracker sheets and confirmed that the facility failed to accurately code R19's urinary incontinence on the 30 day MDS. E9 stated R19 should have been coded as frequently incontinent of urine. Due to the 4/10/12 MDS coding error, it incorrectly appeared that R19's urinary incontinence status improved (from frequent to occasional), when it did not. 4. R29's 14 day MDS, dated 1/22/12, coded the resident as frequently incontinent of urine. E9 (RNAC) was interviewed on 7/2/12. She reviewed applicable ADL tracker sheets and confirmed that the facility failed to accurately code R29's urinary incontinence on the 14 day MDS. E9 stated R29 should have been coded	F 278		

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F 278	Continued From page 4 always incontinent.	F 278		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for four (R178, R228, R27 and R187) out of 40 sampled residents the facility failed to develop care plans based on the needs identified in the comprehensive assessment. Findings include: Cross refer F329 1. R178 had a new physician's order dated	F 279	1.) (a).R 178's care plan was initiated for anxiety. (b).R 178's care plan for bowel and bladder was reviewed and revised to include check and change every two hours. R 178 is currently on a three day voiding diary. Care plan will be reviewed and revised based upon further findings. (c). R 228's care plan was revised to include swallowing strategies. (d). R 27 no longer resides at facility. (e) R 187 no longer resides at facility 2.) All Residents having care plans associated with anxiety, incontinence, swallowing strategies and pain are at risk for this deficient practice	

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F 279	Continued From page 5 6/18/12 for Ativan 0.5 mg every 6 hours prn (as needed) for increased agitation/anxiety. Review of nurses notes documented episodes of agitation, anxiety, refusing care and combativeness. Review of the clinical record lacked evidence that a care plan had been established for R178's new onset of anxiety. An interview with the E3 (ADON) on 7/2/12 at 4 PM confirmed that there was no care plan for R178's new onset of anxiety. 2. Cross refer F315 example #3 R178 was admitted on 5/29/12. The admission MDS dated 6/9/12 documented the resident was always incontinent and not on a toileting program. The care plan initiated 6/7/12 for urinary and bowel incontinence related to impaired cognition and weakness included the goal resident would be clean, dry and free from odor related to incontinence. Interventions included; completing voiding diary on admission and as needed for changes in condition, monitor effectiveness of the toileting schedule and revise as needed, toileting schedule based on voiding diary and document response. Evaluation for bowel and bladder 6/7/12 documented incontinent care every 2 hours and prn (unable to determine a toileting program). An interview on 6/29/12 at 11:50 AM with E13 (LPN) revealed that the voiding diary conclusion was for every two hours. She stated that the	F 279	3.) (a). The Staff Developer or designee will in-service the Licensed Nurses on the initiation of care plans for a new onset of anxiety. (b). The Staff Developer or designee will in-service the Licensed Nurses on the generation of care plans related to continence status. (c). Swallowing strategies will be given to the Unit Manager or designee for revision and or updates of care plans (d). The Staff Developer or designee will in-service the Licensed Nurses on the initiation and revisions of care plans for pain 4.) (a). The Unit Managers or designee will perform weekly random audits on care plans to evaluate whether Residents with anxiety are care planned, bladder status is care planned, swallowing strategies are care planned and care plans are initiated and revised for pain. (b). The results of these audits will be forwarded to the QA &A Committee for their review. The QA &A Committee will determine the need for further audits and or action plans. 9/18/12	

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F 279	Continued From page 6 aides check the resident every two hours, if she is wet they change her if she is dry they toilet her. An interview on 6/29/12 with E3 (ADON), revealed the conclusion of the voiding diaries were to stay on every two hour check and change. R178's care plan did not reflect the comprehensive assessment and was not individualized to meet the resident's needs. 3. R228 was admitted to the facility with diagnoses that included a Cerebral Vascular Accident and Alzheimer's disease. On 4/30/12 a dining screening was completed that recommended rehabilitation for further assessment. Speech Therapy assessed R228 and initiated a "Swallowing guidelines" that included: "mechanical soft diet. -sit up right 90 degrees -stay upright for at least 30 minutes -put chin on chest for swallowing" Review of R228's care plans revealed the facility failed to develop a care plan that included the swallowing guidelines for R228. On 6/28/12 at 12:05 PM interview with E 25 (Speech Therapist SLP) and E5 (RN Unit Manager) confirmed the facility failed to develop a care plan that included the swallowing strategies recommended by the speech therapist. 4. R27 was admitted to the facility with diagnoses	F 279		

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F 279	Continued From page 7 that included depression and anxiety. Review of R27's May 2012's behavior monitoring sheets revealed the facility was monitoring her for insulting comments to staff, yelling out, derogatory and sexual comments to staff. Review of R27's care plans revealed the facility failed to develop a care plan with interventions addressing these behaviors. Review of R27's care plan with E24 (social worker) on 7/2/12 at 2:50 PM confirmed the facility failed to develop and implement a care plan that addressed R27's behaviors towards the staff. 5.Cross refer F309, example 1. R187 was admitted to the facility on 1/13/12 with diagnoses including abdominal aortic aneurysm (AAA) without mention of rupture, hypertension (HTN), hyperlipidemia, right hip pain secondary to iliopsoas muscle and tendon tear (the muscle starts at the lower back and inserts into the thigh bone), macular degeneration, and gastroesophageal reflux disease (GERD). The admission Minimum Data Set (MDS) assessment dated 1/20/12 documented that R187 was independent with daily decision making, received a PRN pain medication within the last five days, was experiencing pain at the time of the assessment of "6" on a scale of "0" to "10" with "10" being the worst pain she can imagine. Care Area Assessment (CAA) Summary noted that a care plan was implemented for pain.	F 279		

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F 279	Continued From page 8 Admission physician's order dated 1/13/12 included Percocet (narcotic pain medication) 5/325 mg. (milligram) one by mouth every 4 hours PRN (as needed) for pain. Review of the Medication Administration Record (MAR) for January 2012 documented that R187 was administered 30 doses of Percocet for January 2012. Although R187 was admitted with diagnosis of right hip pain secondary to iliopsoas muscle and tendon tear and was experiencing pain requiring Percocet 5/325 mg. on 1/13/12 at approximately 6 PM, record review lacked evidence that the facility comprehensively assessed the pain utilizing the "Comprehensive Pain Assessment Form for Alert and Cognitively Impaired Residents" per the facility's policy. In addition, record review lacked evidence that the facility developed and implemented a care plan for the right groin area pain. An interview with E2 (Director of Nursing) on 7/3/12 at approximately 12 noon confirmed that the facility failed to develop and implement a care plan for the right groin area pain.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the	F 280		

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F 280	Continued From page 9 comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to periodically review and revise the comprehensive care plan by a team of qualified persons after each assessment for one (R5) out of 40 sampled residents. Findings include: R5 had a care plan for "Hospice/Palliative Care" initiated on 8/13/10 with a goal that R5 will be comfortable, pain free, and will have advance directives honored by staff for 90 days. The latest revision date on this care plan was 7/6/11. Record review lacked evidence that the facility periodically reviewed and revised this care plan. An interview with E10 (Director of Staff Development) on 6/29/12 at approximately 11 AM confirmed the above.	F 280	1.) R 5's care plan has been reviewed and revised (if applicable) on the following dates: 10/27/11, 1/8/11, 4/12/11. 6/6/11, 7/5/11, 9/28/11, 12/22/11, 3/12/12, and 6/4/12 2.) All Residents with hospice/palliative care plans are at risk for this deficient practice 3.) The Staff Developer or designee will in-service the Licensed Nursing Staff on the review and revision of care plans when applicable. 4.) The Unit Manager or designee will perform random weekly audits on hospice/palliative care plans to evaluate whether they have been reviewed and revised as applicable. The QA &A Committee will determine the need for further audits and or action plans 9/18/12	
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309		

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F 309	Continued From page 10 provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other documentation as needed it was determined that the facility failed to ensure that six (R187, R45, R178, R26, R225 and R27) out of 40 sampled residents received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. The facility failed to comprehensively assess R187, R45, R178 and R27's pain and failed to consistently monitor the effectiveness of the pain management regimen. The Facility failed to provide care and service for R26's Hickman catheter. The facility failed to follow the physician orders for R225's therapy services and R27's pain medication. Findings include: PAIN MANAGEMENT: Review of the facility's policy and procedure titled "Pain Management Protocol" documented: "Procedure: Per AHCPR (Agency for Healthcare Research and Quality)Guidelines, the elderly population is at risk for inadequate pain relief. Pain assessment tools should be objective and simple. The outcome criteria for the pain management protocol is the patient's comfort status which may be verbalized and/or evaluated	F 309	1.) (a) Resident 187 no longer resides at the facility. (b).R 45's medication management for pain has been reviewed by MD. Pre and post pain scores are being documented on the Medication Administration Record (c). Resident 178's pre and post pain scores are being done for Fentyl patch and extra strength Tylenol PRN (d). R 26'S Hickman catheter was removed (e) R 225 no longer resides at center (f) Resident 27 no longer resides at center 2.) (a, b, c, f). Residents receiving pain medication are at risk for this deficient practice (d). Residents with Hickman Catheters are at risk for this deficient practice (e). Residents receiving Physical Therapy are at risk for this deficient practice (f). Residents in need of having controlled substances called in to Pharmacy are at risk for this deficient practice	

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F 309	Continued From page 11 by appropriate healthcare staff. 1. The nurse will complete a comprehensive pain assessment upon admission, re-admission, or based on clinical judgement. At a minimum, a quarterly review will be completed as per the care plan schedule. Complete the appropriate sections on the assessment related to resident's cognitive status. 2. For residents receiving prn (as needed) pain medications, the resident's self-description of the level of pain being experienced will be recorded on the medication administration record utilizing the appropriate pain scale. The same scale will be used to record the effectiveness of the pain relief intervention. The resident's self-description of pain will be documented prior ot administration and 30-60 minutes after administration on the Medication Administration Record (MAR). In residents with cognitive impairment, the observational scale will be utilized. 3. All residents will be assessed for pain every shift and results recorded on the "Pain Flow Sheet". 5. Once a determination has been made of the existence of pain, the physician/licensed independent practitioner will be consulted if pain management is needed or if a change in the resident's regime is needed. 6. The nurse and the interdisciplinary team will evaluate the effectiveness of medication administration. 8. Based upon MDS assessment if a resident triggers for pain, in any section of J, a care plan for pain will be developed. An interim care plan will be established at the report of pain. The plan of care will be evaluated on an on-going basis. The following pain management standards were	F 309	3.) (a). The Staff Developer or designee will in-service the Licensed Nurses on obtaining and documenting pre/and post pain scales on those Residents receiving medications for pain management. The Staff Developer or designee will in-service the licensed Nursing staff on the completion of pain assessments. The Staff Developer or designee will in-service the Nursing Staff on the use of the Behavior Pain Scale. (b). The Staff Developer or designee will in-service the licensed Nursing staff on the flushing of the Hickman Catheter, per Physician order. The Staff Developer or designee will in-service the licensed nursing staff on dressing changes for Hickman Catheters (c) Hospital records will be reviewed by Physical Therapy Department to evaluate weight bearing status orders (d). Pain Medication orders will be reviewed to evaluate whether they are written per MD's order onto the Medication Administration Record.	

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CADIA REHABILITATION CAPITOL	1225 WALKER ROAD DOVER, DE 19901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 12 approved by the American Geriatrics Society in April 2002 which included: - appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management. 1. R187 was admitted to the facility on 1/13/12 with diagnoses including abdominal aortic aneurysm (AAA) without mention of rupture, hypertension, hyperlipidemia, right hip pain secondary to iliopsoas muscle and tendon tear (the muscle starts at the lower back and inserts into the thigh bone), macular degeneration, and gastroesophageal reflux disease. The admission Minimum Data Set (MDS) assessment dated 1/20/12 documented that R187 was independent with daily decision making, received a PRN (as needed) pain medication within the last five days, was experiencing pain at the time of the assessment of "6" on a scale of "0" to "10" with "10" being the worst pain she can imagine. Care Area Assessment (CAA) Summary noted that a care plan was implemented for pain. Review of the admission "Comprehensive Pain Assessment Form for Alert and Cognitively Impaired Residents" dated 1/13/12 documented that R187 was not experiencing pain at the time of the assessment. The section titled "History of Pain was blank.	F 309	4.) (a). The Unit Managers and or designee will perform random weekly audits to evaluate whether pre and post pain scores are being documented onto the Medication Administration Record (b). The Unit Manager or designee will perform weekly audits of pain assessments for completion. (c). The Unit Managers and or designee will perform weekly audits on residents with Hickman Catheters to evaluate whether flushes are being done per physician orders. The Unit Manager or designee will perform weekly audits on residents with Hickman Catheters to evaluate whether dressing changes are being done per physician orders. (d). The Physical Therapy Director or designee will perform weekly audits on Physician orders to evaluate whether the transfer status matches their plan of care.	

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F 309	Continued From page 13 Admission physician's order dated 1/13/12 included Percocet (narcotic pain medication) 5/325 mg. (milligram) one by mouth every 4 hours PRN for pain. R187 had a care plan for "Potential for pain R/T (related to) AAA" initiated on 1/23/12 with a goal that R187's pain will be controlled to a level that is comfortable for her times 90 days. Interventions included: - Report lack of pain control to MD for medication adjustment as needed. - Trial non-pharmacological measures-back rug (sic), quiet environment, position change, soft music, etc. - Use pain scale when assessing for pain both before and after med. administration. - Administer pain medication as per MD orders and note the effectiveness. - Give PRN meds for breakthrough as per MD orders and note the effectiveness. - Reposition as needed for comfort. - Implement relaxation techniques to assist with pain control. Review of R187's documentation titled "Pain Flow Sheet" for January 2012 (January 13, 2012 through January 31, 2012) included a section to document R187's "Acceptable Level of Pain", however, this was blank. Additional information on this flow sheet included: - "Do you have pain": 23 out of 54 shifts, R187 reported "yes." - "Intensity of pain" utilizing scale of "0"-no pain; "1. 1-3"-mild pain; "2. 4-6" moderate pain; "3. 6-8"-severe pain; "4. 8-10" - worst pain; and "5. unable to determine." R187 reported "4" or "worst pain" for 12 out of 54	F 309	(e). The Unit Managers or designee will audit weekly Physician orders to evaluate whether they are transcribed correctly on the Medication Administration Record, The results of these audits will be forwarded to the Quality Assurance and Assessment meeting, The Quality Assurance and Assessment Committee will determine the need for further audits and or action plans. 9/18/12	

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shifts; "3" or "severe pain" for 7 out of 54 shifts; "moderate pain" for two (2) out of 54 shifts; "mild pain" for one (1) out of 54 shifts.
- "Location of pain": "right groin" was documented for 22 shifts.
- "Response to interventions acceptable to resident": 22 shifts was documented as "yes."

An interview with E20 (Registered Nurse Clinical Services Consultant) on 7/6/12 at 10 AM confirmed for the above "Intensity of pain" rating. both "6" and "8" were included in two different intensity of pain categories and that the facility was no longer utilizing the above scale due to this issue.

Although R187 was admitted with diagnosis of right hip pain secondary to iliopsoas muscle and tendon tear and experienced pain requiring Percocet 5/325 mg. on 1/13/12 at approximately 6 PM, record review lacked evidence that the facility comprehensively assessed the pain utilizing the "Comprehensive Pain Assessment Form for Alert and Cognitively Impaired Residents" per the facility's policy. In addition, record review lacked evidence that the facility developed and implemented a care plan for the right groin area pain. Lastly, record review lacked evidence that once a determination had been made of the existence of pain, R187's attending physician was consulted to determine if a change in the resident's regime was needed.

An interview with E3 (Assistant Director of Nursing) on 7/3/12 at approximately 9 AM confirmed that the facility failed to comprehensively assess R187's right groin area pain. An interview with E2 (Director of Nursing)

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F 309	Continued From page 15 on 7/3/12 at approximately 12 noon confirmed that the facility failed to develop and implement a care plan for the right groin area pain. Review of the Medication Administration Record (MAR) for January 2012 documented that R187 was not ordered a scheduled pain medication and that R187 was ordered Percocet 5/325 mg. one by mouth every 4 hours PRN for pain. R187 was administered 30 doses of Percocet for January 2012. Staff assessed and documented R187's pain intensity prior to the administration of the Percocet utilizing the numerical scale of "0" no pain to "10" worst pain as follows: - 19 times, pain was rated between "10-8" (horrible pain/worst pain). - 10 times, pain was rated between "7-5" (severe pain). - One (1) time, no assessment of pain documented. Reassessments of the pharmacological intervention (Percocet) were reviewed. Of the 30 administrations of the Percocet, there was no evidence of a reassessment for nine (9) administrations. On 1/23/12 at 8 AM, post assessment documented no effect and pain level remained unchanged at "7" with movement. Most of the remaining reassessment revealed pain intensity level of "6" or less. Although the facility was assessing R187's right groin area pain prior to the administration of the Percocet, the facility failed to consistently reassess the pain after the administration to determine the effectiveness of the medication. R187's "Pain Flow Sheet" for February 2012	F 309		

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F 309	Continued From page 16 revealed the following: - The "Acceptable Level of Pain" remained blank. - "Do you have pain": 34 out of 82 shifts, R187 reported "yes." - "Intensity of pain": R187 reported "4" or "worst pain" for 18 out of 82 shifts; "3" or "severe pain" for 4 out of 82 shifts; "moderate pain" for 7 out of 82 shifts; "mild pain" for five (5) out of 82 shifts. - "Location of pain": "right groin" was documented for 14 shifts and the "back" area for 12 shifts. - "Response to interventions acceptable to resident": 32 shifts was documented as "yes" February 2012 (MAR) was reviewed and R187's pain regimen remained unchanged with no scheduled pain medication and R187 was administered 22 doses of Percocet for right groin pain and 8 doses of Percocet for back pain. Staff documented R187's pain intensity prior to the administration of the Percocet utilizing the numerical scale of "0" no pain to "10" worst pain as follows: - 18 times, pain was rated between "10-8." - 9 times, pain was rated between "7-5." - One (1) time, no assessment of pain documented. Reassessment of the pharmacological intervention were reviewed. Of the 30 administrations, there was no evidence of a reassessment for six (6) administrations and most of the remaining reassessment revealed pain intensity level of "6" or less. An interview with E12 (attending physician) on 7/5/12 at approximately 11:45 AM revealed that he did not recall whether he was consulted	F 309		

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F 309	Continued From page 17 related to R187's pain management. The facility failed to assure that the pain management protocol for R187 met the professional standards of clinical practice as defined by American Geriatrics Society and their own facility policy. Although R187 was admitted with a diagnosis of right hip pain secondary to iliopsoas muscle and tendon tear and experienced pain on the day of admission on 1/13/12, the facility failed to comprehensively assess this pain including R187's goal for pain management. These failures resulted in lack of care plan development and implementation. In addition, the facility failed to ensure regular reassessment and follow-up utilizing the same quantitative pain assessment scales for initial and follow up assessment; set standards for monitoring and intervention; and to collect data to monitor the effectiveness and appropriateness of pain management. 2. R45 was admitted on 1/13/12 with diagnoses which included stroke (CVA), respiratory failure, cardiac arrest, hypertension (HTN), hyperlipidemia, gastro esophogeal reflux disease (GERD,) diabetes (DM2) and left sided weakness. R45's comprehensive pain assessment dated 1/13/12 indicated the use of the face pain scale (a scale of face pictures ranging from smiley face to crying face), no current pain and facial expressions / moaning as expressions of pain. The assessment also documented the resident was unable to verbalize the pain goal/nurse will determine goal.	F 309		

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F 309	Continued From page 18 The resident's quarterly MDS dated 4/10/12 indicated severe cognitive impairment. The MDS also indicated that the resident used routine and prn pain medication and did not receive non-medication interventions for pain. The assessment also indicated the resident frequently had pain with the highest level being a 2 on a 0 to 10 pain scale. R45 had a care plan initiated on 1/25/12 for potential for pain related to CVA, GERD, and immobility. The goal was for the resident to be controlled to a level that was comfortable for him for the next 90 days. Interventions included; trial non-pharmological measures - back rub, quiet environment, position change, soft music etc., use pain scale when assessing for pain both before and after medication administration, give prn medications for breakthrough as per MD orders and note the effectiveness. The June MAR listed the resident's acceptable pain score as 2. The resident was on a Fentanyl patch 50 mcg/hr for pain and Neurontin 300 mg twice a day for leg pain. R45 also had an order for Vicodin 5/500 mg every 6 hours as needed for pain. Review of the facility's Pain Management Protocol documented "For residents receiving prn pain medications, the resident's self-description of the level of pain being experienced will be recorded on the medication administration record utilizing the appropriate pain scale. The same scale will be used to record the effectiveness of the pain relief intervention". It further documented "In residents with cognitive impairment, the	F 309		

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F 309	Continued From page 19 observational scale will be utilized". Review of the June 2012 MAR revealed R45 received 40 doses of prn Vicodin. Nursing staff assessed the pain using a pain scale before the administration of medication 8 times (20%) and after the administration 7 times (18%). The Behavorial Observational Scale and Face Scale was available in the MAR book. An interview with E14 (nurse) on 6/29/12 at 2:35 PM revealed that she does not use a scale for the cognitively impaired but assesses the resident for facial and verbal expressions. An interview on 7/2/12 at 11:45 AM with E15 (LPN) revealed that she documents the behavior the resident was exhibiting for pain, like moaning. E15 was aware of the behavioral pain scale but admitted that she was not using it correctly. An interview on 7/2/12 at 4 PM with E3 (ADON) confirmed that a pain scale should be done before and after medication administration. 3. R178 was admitted on 5/29/12 with diagnoses which included lupus, rheumatoid arthritis (RA), and osteoporosis. The admission MDS dated 6/9/12 indicated the resident was severely cognitively impaired, the resident received routine and prn pain medication but no non-medication interventions and the resident had not had pain in the past five day of the assessment period. The initial pain assessment conducted on 5/29/12 documented that the resident was not currently	F 309		

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having pain, that a behavorial observation scale was used to assess pain and that an acceptable pain level was 1.

The June 2012 MAR documented that the resident's acceptable pain level was 0 on a 0 - 10 scale.

R178 had a care plan initiated on 6/7/12 for potential for pain related to RA, osteoporosis and lupus. The goal was for pain to be controlled at a level that was comfortable to the resident. Interventions included; trial non-pharmological measures - back rub, quiet environment, position change, soft music, etc., use pain scale when assessing for pain both before and after medication administration and give prn medications for breakthrough as per MD orders and note the effectiveness.

The resident was currently on Fentanyl 12 mcg/hr patch for pain and Flexeril 10 mg three times a day for muscle spasms

R178 had a new order dated 5/29/12 for extra strength Tylenol 500 mg two tablets every 4 hours as needed for pain. Review of the June 2012 MAR documented that the resident received the Tylenol three times. A pain scale was used pre-administration for one out of three opportunities and not used at all post administration.

On 6/29/12 at 2:40 PM E14 (LPN) revealed that R178 had the Tylenol added after the fall due to increased pain. She stated that she used facial expressions like grimacing and saying Oh or ouch. She confirmed that she does not use a

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F 309	Continued From page 21 numeric scale to evaluate pain. She puts the behavior and the effectiveness on the back of the MAR. An interview on 6/2/12 at 4 PM with E3 (ADON) confirmed that a pain scale was not consistently being used pre and post assessment of prn pain medication administration. 4. R26 was admitted to the facility on 5/18/12 with diagnoses including end stage renal disease with hemodialysis 3 times per week, diabetes mellitus, dementia and multiple myeloma. Review of R26's care plan included potential for infection at site of central line (Hickman catheter) left chest wall, dated 5/28/12. Interventions included: change dressing weekly and as needed, flush with 10 mls. NSS (normal saline solution) followed by 5 mls. Heparin (to keep catheter patent) daily (while not in use). IV Therapy Flow Sheets were reviewed from 5/18 through 6/26/12. The flushes with NSS and Heparin were ordered to be done on the 3-11 shift daily. Flushes were not performed for 24 out of 40 opportunities. There were 2 times when the Hickman catheter was not flushed for 5 days in a row. The dressing change on the Hickman catheter was also ordered to be done weekly and as needed on the 3-11 shift. The facility failed to flush the Hickman at all from 5/18 through 6/26/12. E2 (Director of Nursing) was interviewed on 6/28/12. He stated that R26's Hickman was not in use, but it was to be left in place in case the resident required intravenous antibiotics. E2	F 309		

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F 309	Continued From page 22 stated that R26 was hospitalized for nearly 5 months prior to admission to the facility with an infection. E2 was interviewed again on 6/29/12. E2 stated that he called dialysis on 6/28/12 post interview to see if they were flushing R26's Hickman catheter and/or changing the dressing and stated "they didn't even know it was there." E2 stated the catheter was flushed without difficulty when the resident returned from dialysis on 6/28/12 and after talking to R26's physician, the resident was sent to the hospital this morning to have the Hickman catheter discontinued for non-use. 5. R225 was admitted to the facility on 4/14/12 with diagnoses that included fracture of the right leg with repair and osteoarthritis. Review of the hospital discharge instructions revealed R225 was to receive rehabilitation services that included "Toe touch only". Review of the facility's admission order sheet dated 4/14/12 and signed 4/15/12 documented "Rehab Potential weight bearing status: WBAT (weight bearing as tolerated)" on the first sheet. On the last sheet of the admission orders under treatments it documented "Toe touch only". Review of Physical Therapy documentation revealed that R225 was to have services that included "WBAT" instead of "Toe touch only." Review of the physical therapy 4/15/12 evaluation and plan of treatment revealed R225 "ambulated with rolling walker x 2 steps with moderate assist."	F 309		

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F 309	Continued From page 23 On 5/1/12 R225 had an appointment with her orthopedic physician. The physician wrote a order to the facility stating "Non weight Bearing x 12 weeks!!!" On 5/31/12 R225 returned to the orthopedic physician, The physician wrote an order for physical therapy to progress R225's treatment to "WBAT". On 6/29/12 at 10:05 AM an interview with E23 (Rehabilitation Director) revealed the therapist transcribed the order wrong and from 4/15/12 through 4/30/12 R225 received the wrong treatment. R225 received WBAT instead of "Toe Touching only" . E23 continued to state when residents are first admitted for rehabilitation the therapist is suppose to check the hospital records as well as the facility orders for accuracy. E23 also stated the facility had not developed a policy and procedure instructing the therapist to check the hospital orders/records on admission. On 6/29/12 at 10:50 AM R225's chart was reviewed with E2 (DON) who stated the day nurse copied the order wrong and the 11-7 nurse found the error and rewrote the order. The 11-7 shift nurse should have crossed out the wrong order on page one as well as writing the correct order under treatments for the physician to sign. 6.a R27 was admitted to the facility from the hospital with diagnoses that included lethargy, drowsiness, change in mental status, urinary tract infection, seizures, CVA (stroke) and Crohn's disease. Review of R27's physician orders revealed on	F 309		

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F 309	Continued From page 24 5/8/12 the physician wrote an order for "Percocet 5-325 mg one tablet by mouth twice a day". Review of R27's MAR revealed she received the Percocet 5-325 mg at 8 AM and 8 PM every day. Review of the facility's C2 (controlled medication form) documented a faxed C2 form with an order for R27 dated 6/11/12 for "Percocet one tablet by mouth every morning and one by mouth every 4 hours as needed." This form was faxed to the pharmacy and signed by the physician. Review of R27's MAR (Medication Administration Record) revealed the facility failed to discontinue the Percocet one tablet by mouth twice a day and initiate the 6/11/12 order for Percocet one tablet by mouth every morning. For 18 days R27 received Percocet medication that was not in accordance with the physician's plan of care. Review of R27's July 2012 MAR and monthly physician order sheet documented the 6/12/12 Percocet order. On 7/2/12 at 11:20 AM a telephone interview was conducted with E27 (Pharmacist) for the facility. E27 stated E12 (physician) called the 6/11/12 Percocet order to the pharmacy as a verbal order. Then the physician faxed a written signed order to the pharmacy. The pharmacy faxed the written order to the facility on the C2 form. On 7/2/12 at 12:02 AM an interview with E2 (DON) confirmed the facility failed to change R27's order for Percocet. E2 continued to state that the physician did not follow the facility's process of contacting the facility first with the order then the orders should have been sent to	F 309		

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F 309	Continued From page 25 the pharmacy. E2 stated the facility should have picked up this medication order change during the monthly change over from June to July. E2 also stated staff do not look at the C2 forms sent from the pharmacy to ensure all orders match. 6b. The facility's Pain Management Protocol documented "For residents receiving prn pain medications, the resident's self-description of the level of pain being experienced will be recorded on the medication administration record utilizing the appropriate pain scale. The same scale will be used to record the effectiveness of the pain relief." R27's care plan for Potential for pain had interventions that included "Use pain scale when assessing for pain both before and after medication administration." Review of R27's record revealed a physician order dated 5/3/12 for Percocet 5-325 mg one po every 8 hours as needed. Review of R27's record revealed the resident was administered the percocet and on the following days and the following assessments were documented: 5/2/12 for c/o pain legs 5/10 (no time just documented effective) 5/3/12 7:00 PM percocet c/o generalized pain 8:00 PM (documented effective) 5/4/12 8:55 AM c/o generalize pain 5/10 (no follow up for effectiveness was documented) 5/5/12 8:50 AM pain 5/10 9:50 AM (effective no pain scale)	F 309		

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F 309	Continued From page 26 5/7/12 percocet 7:50 AM c/o generalized pain 3/10 9:00 AM (documented effective) Review of R27's pain assessment with E2 (DON) and E5 (RN Unit Manager) on 7/2/12 at 12:30 PM confirmed R27's complaints of pain should have been consistently assessed, before and after the administration of pain medication, utilizing the pain scale.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and interview, it was determined that the facility failed to ensure that three (R19, R29 and R178) out of 40 sampled residents who were incontinent of bladder received appropriate treatment and services to restore as much normal bladder function as possible. The facility failed to accurately assess and reassess the voiding status of R19, R29 and R178 and subsequently, they failed to implement individualized toileting programs and care plans for urinary incontinence. Findings include:	F 315		

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F 315	Continued From page 27 The facility policy entitled " ... Continence Assessment Process " , dated 10/10, stated, " On Admission, quarterly as part of the MDS process, or with change in condition, all residents will be assessed for voiding ... patterns for three days to determine whether they are continent and if not whether the potential exists for a bladder ... retraining, scheduled toileting or check and change program. " Additionally, the policy stated, " The morning following admission the assessment process begins with the initiation of the 3 Day Voiding ... Diary ... note on the form the status of the resident each time taken to the bathroom and results of toileting ... At the end of this three day period the DON (Director of Nursing) or designated Nursing representative is to review the Voiding ... Diary Form and complete the Assessment for Bowel and Bladder Training form. The entire process on admission should be completed by day seven ... program is to be written out. The care plan is updated and all staff educated as to their role. Quarterly as part of the care plan process, both the Three Day Voiding ... Diary and the Assessment for Bowel and Bladder Training are to be repeated to determine if changes have occurred in the resident status which would warrant a change in continence interventions. If on a prior assessment it is determined that the resident is not able to participate in bladder retraining or scheduled toileting and there has been no change in the Assessment for Bowel and Bladder Retraining, the three day voiding diary does not have to be repeated quarterly. Those residents who are on a program are to be re-evaluated to determine	F 315	1.) R 19, R 29 and R 178 had a bowel and bladder assessment completed. R 19, R 29 and R 178 had a three day voiding diary completed. An individualized toileting program was added to the R 19, R 29 and R 178's plan of care.. 2.) All Residents with urinary incontinence are at risk for this deficient practice. . 3.) (a). Continence Assessment Process Policy will be reviewed and revisions will be made if applicable. (b). The Staff Developer or designee will in-service the licensed nurses on the Continence Assessment Process Policy. (c). The Staff Developer or designee will in-service the Certified Nursing Assistants on completion of voiding diaries.	

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F 315	Continued From page 28 program effectiveness and changes are to be made as indicated. The care plan is to be updated with any change made to the treatment plan. " 1.R19 was admitted to the facility on 3/15/12 with diagnoses including diabetes mellitus, hypertension, a history of bladder cancer and stroke. The Interagency Nursing Communication Record, dated 3/15/12 (completed by the hospital prior to R19 ' s admission to the facility) stated R19 was " incontinent c (with) urine. Continent at times. " The admission MDS, dated 3/22/12, stated R19 was a one person extensive assistance with toileting, she had occasional incontinence, no current toileting program and she was a "9"(moderately impaired) (out of 15) for BIMS score (Brief Interview for Mental Status). On 3/28/12, R19's 14 day MDS BIMS score increased to "12"(cognitively intact) , yet she declined to frequently incontinent of urine and had no toileting plan. On 4/10/12, R19's 30 day MDS revealed a BIMS score was "13" (cognitively intact) (continued to increase), toileting required one person total dependence, there was occasional urinary incontinence and no toileting plan. On 6/14/12, R19's quarterly MDS revealed a BIMS score of "14"(cognitively intact) , always incontinent of urine and no toileting plan. On 7/3/12 at 9:30 AM, R19 was observed sitting	F 315	4.) (a). The Unit Manager or designee will perform random weekly audits of bowel and bladder assessments to evaluate timeliness of completion. The Unit Manager or designee will perform random weekly audits of voiding diaries to evaluate whether they are completed. The results of the audit will be forwarded to the Quality Assessment and Assurance Committee for their review. The Quality Assessment and Assurance Committee will determine the need for further audits and or action plans. 9/18/12	

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up in bed finishing her breakfast independently. R19 indicated she was very hard of hearing and for the surveyor to use a dry erase board in her room. R19 was alert and answered questions appropriately.

Review of the care plan for R19, included occasional urinary incontinence, dated 3/23/12, which stated the resident would be clean, dry and free from odor related to incontinence. Interventions included: completing voiding diary on admission and as needed for changes in condition, monitor effectiveness of the toileting schedule and revise as needed, toileting schedule based on voiding diary and document response and check and change pads/briefs as appropriate. There were no revisions to R19 ' s care plan. It was unclear from reviewing the care plan what incontinence program R19 was on.

Review of the clinical record lacked evidence that the facility initiated a 3 day voiding diary as per facility policy, yet an Assessment for Bowel and Bladder Training (to be completed after review of 3 day voiding diary) was completed on 3/16/12 which stated that R19 was usually continent (incontinence episodes once week or less) and that R19 dribbles.

Although a decline in R19's urinary incontinence was documented on the 14 day MDS, a voiding diary was not initiated.

The facility initiated a 3 day voiding diary on 4/14/12, a month after R19 was admitted to the facility. From 4/14/12 to 4/16/12, R19 was found to be wet 17 times, dry 35 times and there were 17 blanks (including 8 hours in a row). Directions

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stated, " In the Column ' Toileting Results ' write in whether the resident urinated, had a BM or if nothing, ' none ' . " There were 4 checks under toileting results and one time " voided. "

Although the 3 day voiding diary was incomplete, an Evaluation for Bowel and Bladder Training, was completed on 4/19/12, which stated that R19 was appropriate for incontinent care every 2 hours and as needed " (unable to determine a toileting program). " The evaluation also stated that R19 did not have a diagnosis that would limit bladder control and "yes" that her health status allowed for participation in retraining.

Review of ADL (Activities of Daily Living) Tracker sheets, completed by CNA's, revealed that R19 from admission in March through June 2012 revealed that R19 progressively declined from a mix of urinary incontinence to nearly always incontinent of urine since May. While the facility completed the 3 day voiding diary it is unclear why this data and the ADL tracker sheet information are not consistent.

An Assessment for Bowel and Bladder Training was done on 6/20/12 which revealed frequent incontinence (daily, but does exhibit some control) and functional incontinence (inability to toilet due to cognitive and/or physical status).

A new 3 day voiding diary was done from 6/29 through 7/1/12. R19 was found to be wet 20 times, dry 40 times and there were 12 blanks (including 7 hours in a row). Under toileting results, there was no information about whether R19 voided or not when toileted and, except for 3 BM's listed, whether R19 was toileted the other

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F 315	Continued From page 31 times. E9 (RNAC) was interviewed on 7/3/12. She reviewed R19's MDS and compared them to the ADL tracker sheets. E9 stated that the admission and 30 day MDS were inaccurate; they should have been coded as frequently incontinent of urine instead of occasional. E9 confirmed that the quarterly MDS, dated 6/14/12, was accurate in coding for always incontinent of urine. Post survey it was determined that the 6/14/12 MDS was inaccurate and should have been coded as frequently incontinent of urine. E9 additionally confirmed that R19's urinary incontinence decline began in May. E28 (CNA) was interviewed on 7/3/12. She stated that R19 is able to stand to be toileted with 2 staff (leans back) and that the resident uses the call bell, but does not call to be toileted. E28 stated when R19 is asked if she needs to go to the bathroom, she says "no", but she is wet. E2 (Director of Nursing) was interviewed on 7/3/12. E2 confirmed that the facility failed to complete a 3 day voiding diary upon admission to determine voiding patterns. He stated that by not initiating a 3 day voiding diary, the facility was unable to assess and implement an individualized toileting plan. E2 also confirmed that R19's urinary incontinence care plan was not individualized and it was not evident what kind of program the resident was on. Prior to the informational meeting on 7/3/12, surveyor reviewed findings with E1 (Administrator), E2 and E 10 (staff development).	F 315		

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F 315	Continued From page 32 The facility failed to complete assessments and reassessments concerning R19's continence status, failed to assess the effectiveness of their interventions and failed to provide the care and services to maintain or restore as much bladder function as possible. 2. R29 was readmitted to the facility on 1/9/12 with diagnoses including overactive bladder (receives medication for this), atypical depressive disorder, bipolar disorder and/or schizophrenia, and a fractured right tibia. She had an indwelling urinary catheter that was removed in the hospital on 1/9/12 prior to return to the facility. Review of R29 ' s admission MDS, dated 1/16/12 and 14 day MDS, dated 1/22/12, listed the resident with BIMS (Brief Interview for Mental Status) scores of "14" and "12" (out of a possible 15) successively, frequently incontinent of urine, no toileting plan and one person extensive assistance for toilet use. MDS ' dated 2/5/12, 3/6/12 and 4/6/12 coded R29 as " 14-15 " for BIMS, always incontinent of urine and 2+ persons total dependence for toileting. A toileting plan was listed beginning on 3/6/12. R29 was observed in bed on 6/28/12 at 10 AM with her television on. She stated that she was "stone deaf", she did not need anything and she had just been bathed. On 6/28/12 at 12:09 PM, R29 indicated she wanted to rest, watch a television program and be left alone. Review of R29 ' s care plan for urinary	F 315		

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incontinence, dated 1/20/12, stated the resident would be clean, dry and free from odor related to incontinence. Interventions included: completing voiding diary on admission and as needed for changes in condition, monitor effectiveness of the toileting schedule and revise as needed, toileting schedule based on voiding diary and document response and check and change pads/briefs as appropriate. There were no revisions to R29's care plan. It was unclear from reviewing the care plan what incontinence program R29 was on. R29's urinary incontinence care plan was not individualized.

Record review lacked a 3 day voiding diary when R29 was readmitted to the facility on 1/9/12. There was not one completed when R29 was initially admitted on 12/30/11 as the resident had an indwelling urinary catheter. According to facility policy, a 3 day voiding diary has to be completed and reviewed to determine what incontinence program the resident needs.

An Assessment for Bowel and Bladder Training was completed on 12/30/11 that indicated R29 had a urinary catheter. The clinical record lacked additional Assessments for Bowel and Bladder Training. A quarterly assessment due in April was also not completed.

Scheduled Toileting Flow sheets were reviewed from 1/27/12 through June 2012. The flow sheets included 4 rounds for each shift (for example, 11-7 first round, second round, etc.) and instructions to mark yes/no if resident voided and to mark if brief was wet or dry. R29 had a mix of being wet and dry and she was marked mostly "no" for voided. It was unclear if resident was

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F 315	Continued From page 34 being toileted and appeared to be an every 2 hour check and change. ADL (activity of daily life) Tracker Sheets, completed by CNA ' s were reviewed from 1/9/12 through 6/30/12. Overall, there was a sustained increase in urinary incontinence since February 2012. E9 (RNAC) was interviewed on 7/2/12. E9 confirmed that the MDS that coded R29 as frequent urinary incontinence (admission and 14 day) were miscoded and should have been coded as always incontinent. E29 (CNA) was interviewed on 6/29/12. E29 stated that the resident uses her call bell about half of the time when she has to urinate, but " other times she doesn't mind being wet. " E29 stated that R29 always uses the call bell to have a BM. E2 (DON) and E10 (staff development nurse) were interviewed on 6/29/12. E10 confirmed that the facility was unable to find a 3 day voiding diary when R29 was readmitted to the facility on 1/9/12. E2 confirmed that the toileting plan (referred to Scheduled Toileting Flow sheets) were initiated late (facility policy is that it will be completed by day 7). E2 stated that because there was a decline in urinary incontinence on the MDS ' since 2/5/12 a 3 day voiding diary should have been implemented by the facility to reassess R29's urinary incontinence and to determine if a change was needed to her toileting plan. E2 also stated that the coding errors on R29's admission and 14	F 315		

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F 315	Continued From page 35 day MDS were discovered on 6/29/12 after the surveyor began discussing concerns regarding R29's incontinence. The facility failed to assess and reassess R29's continence status and failed to provide care and services to maintain or restore bladder function. 3. R178 was admitted on 5/29/12 with diagnoses which included RA, Lupus and a brain tumor. The admission MDS dated 6/9/12 indicated the resident was severely cognitively impaired, was dependent for toileting with two person physical assistance, was not on a toileting program and was always incontinent. Admission Nursing Assessment dated 5/29/12 documented the resident was incontinent of urine. The Unit Manager/Supervisor Admission Chart Check incorrectly documented the resident was not incontinent or having incontinent episodes. The Assessment for Bowel and Bladder dated 5/29/12 documented the resident was unaware of bowel/bladder urges, mobility assistance required and frequent incontinence. A voiding diary was completed 5/30, 5/31 and 6/1/12. The resident was noted out of 72 opportunities to void 9 times, was dry for 41 entries and had no documentation for 17 entries. The care plan initiated on 6/7/12 for urinary and bowel incontinence related to impaired cognition and weakness included the goal resident wound be clean, dry and free from odor related to	F 315		

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F 315	Continued From page 36 incontinence. Interventions included; completing voiding diary on admission and as needed for changes in condition, monitor effectiveness of the toileting schedule and revise as needed, toileting schedule based on voiding diary and document response. The evaluation for bowel and bladder dated 6/7/12 documented the resident was incontinent 75% of the time, continent during the day and in bed, does not feel loss of control, health status does not allow for retraining, no diagnosis to limit bladder control, incontinent care every 2 hours and prn (unable to determine a toileting program). Review of facility documentation revealed that R178 had a fall from her wheel chair on 6/17/12. Review of the Fall Committee Review dated 6/20/12 documented a toileting plan was requested, A new voiding diary was completed 6/20, 6/21, and 6/22/12. Out of 72 opportunities, the resident was found wet 21 times, dry 47 times, voided nine times and had no documentation of results of the toileting 59 times. It was unclear whether staff actually toileted the resident when the results column was blank. The conclusion of this assessment by nursing staff was to continue with check and change every two hours. An interview on 6/29/12 at 11:50 AM with E13 (LPN), revealed that the voiding diary conclusion was for every two hours. She stated that the aides check her, if she is wet they change her if she is dry they toilet her. An interview on 6/29/12 at 2:10 PM interview with	F 315		

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F 315	Continued From page 37 E16 (CNA) revealed that R178 was both continent and incontinent. When she is real alert she can tell you she has to go and she will be dry and void in the toilet. E16 stated that she checks on R178 every two hours and toilets at times. An interview on 7/2/12 at 4 PM with E3 (ADON) confirmed that this resident was on an every two hour check and change program for urinary incontinence. There was no evidence in the clinical record or by interview that the facility was attempting to maintain or restore bladder function for R178.	F 315		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and review of facility's policies, it was determined that the facility failed to maintain acceptable parameters of nutritional status such as body weight for one (R187) of 40 sampled residents. The facility's system failed to identify a severe weight loss for	F 325	1. Resident #187 no longer resides at the facility. 2. All Residents with weight variances are at risk for this deficient practice. 3. (a) The Staff Developer or designee will in-service the Nursing Staff on the reweigh criteria including the notification of the Physician with significant weight variances. (b) If Nursing determines that a significant weight variance has occurred, Nursing will notify the Registered Dietician. The Registered Dietician will implement interventions as applicable.	

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F 325	Continued From page 38 R187 for two weeks and failed to implement interventions to address the weight loss. In addition, the facility failed to have a system in place to verify and analyze weight changes in a timely manner. Findings include: R187 was admitted to the facility on 1/13/12 with diagnoses including abdominal aortic aneurysm (AAA) without mention of rupture, hypertension (HTN), hyperlipidemia, right hip pain secondary to iliopsoas muscle/tendon tear (area of groin), macular degeneration, and gastroesophageal reflux disease. R187's "Resident Admission Assessment" documented a height of 65 inches, weight of 175.6 # (pounds), and R187 had one plus edema of left ankle. Review of the admission physician's orders dated 1/13/12 documented "weekly weight times 4." On the day after the admission, R187 was re-weigh and weighed 174.4#. Review of the admission Minimum Data Set (MDS) assessment dated 1/20/12 documented that R187 was independent with daily decision making, was independent with eating and required set-up only. In addition, R187's height and weight was 65 inches and 174 pounds (#) respectively. Subsequent MDS assessments dated 2/9/12 documented R187 remained independent with daily decision making, was independent with eating and required set-up only and that her weight was 156 # (approximately 18 # loss). Lastly, the assessment was incorrectly coded that R187 was a physician prescribed	F 325	4. (a).The Unit Manager or designee will perform weekly random audits to evaluate whether the reweighs are done according to the weekly weight worksheet criteria. (b) The Unit Manager or designee will perform weekly random audits to evaluate whether the Physician has been notified with significant variances in weights .(c). The results of the audit will be forwarded to the Quality Assessment and Assurance Committee for their review. The Quality Assessment and Assurance Committee will determine the need for further audits and or action plans. 9/18/12	

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F 325	Continued From page 39 weight loss regimen. R187's initial registered dietician assessment dated 1/16/12 by E4 (Registered Dietician) documented height of 65 inches and weighed 174# (1/14/12). Estimated fluid requirement of 1,550 cc per day and the estimated caloric needs per day was 1,515. In addition, R187 had plus one left ankle edema. The care plan titled "Nutrition Status: Moderate Nutrition risk per nutritional assessment, therapeutic diet, HTN, and AAA created on 1/16/12 included a goal that R187 ' s PO (oral) intake will be greater than 75% of needs and resident will maintain adequate hydration X 90 days. " Interventions included: - Monitor labs. (laboratory results) as ordered. - Monitor PO intake, weight, skin, and meds are ordered. - Provide diet as ordered NAS, centrum silver daily. - Weekly weights X 4 then monthly if stable. The admission blood work at the facility dated 1/17/12 indicated that the resident's blood urea nitrogen (BUN) level was 21 (normal range 10-26 mg /dl) and that the creatine (creat.) level was 0.6 (normal range 0.5-1.5 mg/dl). In addition, the sodium level was within normal at 139 (normal range 135-145 mmol/L). BUN, creatinine, and sodium levels are indicators of fluid imbalance and renal function. Review of R187's meal intake records from 1/13/12 through 1/20/12 (seven days) indicated that she consumed an average of 65% of her	F 325		

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F 325	Continued From page 40 meals. R187 ' s first weekly weight on 1/21/12 was documented as 164.3 (fluctuation of 10.1# or 5.7% weight loss in one week), The facility policy entitled "Weights-Taking & Recording-Monthly & Weekly " was reviewed. Under the procedure it stated that : " 2. Weekly weights will be taken weekly and documented on the same week ... " " 5. Re-weights will be done on any resident who experiences: 5 pounds weight fluctuation and is >/= 100 pounds." 7. Once the weight fluctuation has been confirmed the Dietician or designee will be notified by Dietary Alert Form (refer to Weight Fluctuation Policy). " An interview with E4 on 7/2/12 at approximately 9 AM revealed that weekly weights were completed on Saturday on the Magnolia Unit and the confirmation of the weight fluctuation as well as the need for re-weigh was determined by nursing on Saturday. If re-weigh was needed, this would obtained on the next day on Sunday. E4 allowed the surveyor to review the above titled policy which included that the " ...re-weigh will be completed immediately or within 24 hours " , however, the same titled policy provided by E10 (Staff Development Coordinator) to the surveyor during the survey failed to include the timeframe for the reweigh to be completed. E4 verbalized that obtaining re-weights have " improved. " An interviews with E2 (DON) and E10 on 7/2/12 at approximately 5 PM confirmed that the current version of the above policy no longer included when re-weights will be completed. In addition, there was no policy and procedure titled " Weight	F 325		

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F 325	Continued From page 41 Fluctuation Policy " as documented in the above policy. Review of additional facility's policy entitled "Weight Changes (Monthly) documented: "Policy: Notification of Interdisciplinary Team, Physician and Family Members of Significant Monthly Changes. Timely notification of the IDT (interdisciplinary team), physician and family members of significant weight changes." " Procedure: 2. Any resident that is noted to have a significant weight fluctuation which is defined as anyone who has 5 # fluctuation if the resident is > or = 100 #. 3. After the weight fluctuation has been confirmed using the guidelines outlined in the facility ' s re-weight policy, the Registered Dietician or designee will be notified by a Diet Alert form. 4. Resident with confirmed significant weight fluctuation will be reported at the next weekly High Risk Committee/appropriate staff by the RD or designee. 6. Once a significant weight loss or gain has been confirmed and reported to the High Risk Committee/appropriate staff the Unit Manager or designed shall be responsible for notifying the resident ' s physician and interested family members of their weight fluctuation. " An interview with E3 (Assistant Director of Nursing) on 7/3/12 at approximately 8:40 AM confirmed that the licensed nurse was responsible to determine the need for a re-weigh and that this needs to be completed immediately or within 24 hours. An interview with E5 (Unit Manager) on 6/29/12 at	F 325		

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F 325	Continued From page 42 approximately 2 PM revealed that the need for reweigh was determined by the Registered Dietician (RD) on the following Monday. Interviews with two certified nursing assistants, E8 and E11 on 7/2/12 at approximately 11:50 AM revealed that weekly weights for new residents in the Magnolia Unit are completed on the day and evening shifts every Saturday. The weekend RN Supervisor reviews the weights and determines the need for the re-weight which are completed the next day on Sunday. Although R187's first weekly weight on 1/21/12 was documented as 164.3 (fluctuation of 10.1# or 5.7% weight loss in one week, record review lacked evidence that the facility confirmed the weight fluctuation, thus, failing to ensure that re-weigh was completed and weight loss verified. These failures resulted in lack of notification of the Registered Dietician, attending physician, R187's interested family member and the High Risk committee. An interview with E4 on 7/2/12 at approximately 9 AM revealed that E4 may have reviewed the above weight on Monday, 1/23/12 and may have requested a re-weigh by notifying the unit manager, however, if this did occur, E4 confirmed that this was not documented. An interview with E6 (RN Supervisor) on 7/2/12 at 1 PM who worked on 1/21/12 and 1/22/12 revealed that she did not recall specifically what occurred on 1/21/12 or 1/22/12, however, E6 verified that the confirmation of the weight fluctuation and the need for the re-weigh would have been completed by the RN supervisor and	F 325		

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F 325	Continued From page 43	F 325		

the re-weigh would have been completed on the following day on Sunday. The need for the re-weigh on the following day would be communicated by documentation on the "24 Hours Shift " report for the following day, 1/22/12.

An interview with E2 (Director of Nursing) on 7/12/12 at approximately 4:30 PM revealed that the facility was not able to locate the "24 Hours Shift" report for 1/22/12.

A subsequent interview with E4 on 7/3/12 at approximately 11 AM revealed that it was her assessment that R187's plan of care would not have changed although the facility failed to verify the weight loss experienced by R187. E4 verbalized that some of the weight loss could have been due to the edema. E4 verbalized that the disciplines responsible to ensure that the intervention on the above care plan for the weekly weights included CNA, Dietician, and Nursing.

Nurses Note (N.N.) on 1/21/12 documented R187 offering complaints of nausea and vomiting.

In response to R187's above complaints and presence of a Norovirus (a very contagious virus with symptoms including stomach pain, nausea, and diarrhea and vomiting) within the facility, hydration monitoring was initiated on 1/21/12 with R187's daily fluid goal of 1,550 cc. The hydration monitoring continued through 2/5/12 and was discontinued on 2/6/12.

Review of the "Nutritional Progress Note" dated 1/24/12 and timed 1:20 PM by E4 documented "Hydration monitor d/t (due to) GI (gastrointestinal) symptoms. Meals refused x 3

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F 325	Continued From page 44 days per nursing. Continue hydration monitor. Food/fluids encouraged. Wt. (weight) 164.3 (1/21/12). Requested reweigh. Wt. 174.4 (1/14/12) check CMP (Complete Metabolic Panel). c/o (complaints of) pain. Will hold supplements until GI resolved. " An interview with E4 on 7/2/12 at approximately 9 AM revealed that the reason that a re-weigh may not have been completed was due to R187 not feeling well and R187 was in bed. E4 verbalized that in these situations, the facility did not typically obtain a re-weigh, however, the attending physician should be notified that a re-weigh was not completed. E4 verbalized that this was "not significant loss." Despite the fact R187 had a significant weight fluctuation of 10.1# on 1/21/12 and E4 documented "requested reweigh" on 1/24/12, record review lacked evidence that the facility re-weighed R187. Upon surveyor's inquiry on 7/2/12, E4 and E2 verbalized that they were able to locate a weight of 169# documented on the cardiologist consultation during an office visit on 1/24/12. Record review revealed a "Change of Diet" slip dated 1/25/12 for "clear liquid diet all meals, no tea" due to R187's complaints of nausea and vomiting on 1/21/12. Review of the CMP completed and dated 1/25/12 documented an elevated BUN of 36 and normal creatine of 0.7. This documentation included the initials of E12 (attending physician) and a date 1/25/12.	F 325		

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F 325	Continued From page 45 A subsequent "Nutritional Progress Note" dated 1/26/12 by E4 documented "Update: Hydration monitoring. Avg. (average) X 3 days. 983 ml (milliliter)/day. Continues with minimal PO food intake. Await reweigh. CAT scan of abd./pelvis. Labs 1/25 BUN/Creat. 36/.7. Na/K 140/3.2. GFR 84.5. Continue hydration mtr. Await CT results prior to addition of supplements. Although E4 identified on 1/26/12 that a re-weight was not completed, record review lacked evidence that the facility re-weighed R187. Subsequent weekly weight obtained on 1/28/12 documented R187 weight was 154.8# (Another 9.5# weight fluctuation/loss in one week). Despite the fact that R187 had another significant weight fluctuation of an additional 9.5#, record review lacked evidence that the facility confirmed the weight fluctuation, thus, failing to ensure that re-weigh was completed immediately or within 24 hours to verify the weight loss. Review of N.N. dated 1/28/12 and timed 11 PM documented "Per family request and resident poor PO intake/wt. loss 20 lbs. since admission. Start IV infusion of NSS (normal saline solution) 0.9 % at 60 cc/hr. Have BMP (Basic Metabolic Panel) on Sunday. Also change Compazine suppository to 10 mg. PO q. (every) 6 hrs. (hours). IV access attempted by 2 RN Supervisors with no success, MD (E12, attending physician) made aware. T.O. (telephone order) give 30 ml water PO q hour and continue with BMP in AM." Review of the BMP results dated 1/29/12	F 325		

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F 325	Continued From page 46 documented worsening BUN to 39, normal creat. 0.8, and an elevated potassium level of 3.1 (normal range of 3.5-5.0). Subsequent N.N. dated 1/29/12 and timed 9:30 PM documented the above BMP results and a new order to increase hourly fluids by mouth to 45 cc and to administer 10 milliequivillant of potassium chloride every hour times four for total of 40 meq. In addition, repeat BMP in AM. Interview with E6 on 7/2/12 at approximately 11 AM revealed that she did not recall what may have happened on 1/28/12 or 1/29/12. These failures resulted in lack of notification of the RD and reported to the High Risk committee on 1/28/12 or 1/29/12, An interview with E2 on 7/3/12 at approximately 1 PM revealed that the IDT Committee was notified of the 20 # weight loss on 2/3/12. On 1/30/12, BMP results documented improving BUN at 31 and normal creatinine at 0.6. Additionally, on 1/30/12, a re-weight was completed as requested by E4 on 1/30/12 and R187 weighed 153.5#, a 10.8# weight loss in one week or 22.1# loss since admission. Subsequent nutritional progress note by E4 dated 1/30/12 " ...wkly wt 154. (1/28) 164.3# (1/21) Requested reweigh. Labs 1/29 BUN 39 K 3.1 GFR 72.4#. IV (intravenous) attempted yet unable to place per nursing. Fluids ordered 45 ml (milliter)/hr. (hour) PO. KCL (Potassium) supplement. Continue with AAA. Avg. PO 3 days < 10%. Took 25% x 2 meals 1/29.	F 325		

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F 325	Continued From page 47 Tolerating small amounts of fluids every hour. Spoke with resident c/o vomiting pill this a.m. UBW (ususal body weight) 175#. If PO cannot be resumed to meet needs may need to consider alternative nutrition. Tolerating fruit only @ meals. Add to q. (every) meal. Labs 1/30 BUN 31 K+ 3.8. Trial Enlive (nutrition drink that contains high-quality protein and essential nutrients) supplement BID (twice a day)." Physician's orders dated 1/30/12 included Enlive 1 carton BID and another order dated 2/3/12, a clarification diet order for "NAS small portions in separate bowls. Fruit cups at each meal/snacks." R187's subsequent weekly weight on 2/4/12 was 155.9# 2/11/12 - 151.7# 2/18/12 - 155.7# 2/25/12 152.7 # An interview with E12 on 7/5/12 at approximately 11:45 AM revealed that he recalled that R187 was losing weight throughout her stay and that R187 had a weight loss of approximately 20# partly due to edema. The facility failed to have a system in place to identify significant weight fluctuations and obtain reweights in a timely manner as per their policy to confirm the weight loss. The facility failed to monitor weights and failed to notify the physician of the significant weight fluctuations causing a delay in the analysis of the reason for the loss and review and implementation of new intervention.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		

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F 329	Continued From page 48 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R178) out of 40 sampled residents the facility failed to monitor the behavior associated with the use of a psychoactive medication. The facility also failed to have evidence that side effect monitoring was being conducted. Findings include: R178 had a new physician's order dated 6/18/12	F 329	1.) R 178's behavior is being tracked on the behavior flow record. The Behavior Intervention Monthly Flow Record to monitor side effects of Ativan has been initiated. 2.) Residents with behaviors are at risk for this deficient practice 3.) (a).The Staff Developer or designee will in-service the Certified Nursing Assistant's on reporting new behaviors to the Licensed Nurse. (b).The Staff Developer or designee will in-service the Licensed Nurses on the initiation of a behavior flow sheet upon the onset of a new behavior. (c).The Staff Developer or designee will in-service the Licensed Nurses on the initiation of the Behavior intervention monthly flow record with the start of Psychotropic Medication. This Behavior intervention monthly flow record includes monitoring of side effects.	

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F 329	Continued From page 49 for Ativan 0.5 mg every 6 hours prn for increased agitation/anxiety. The facility's policy for Behavior Management Program documented that "Behavior management begins with observation of a new behavior. Nursing will determine at what point a new behavior will be targeted for tracking, identify the target behavior and document occurrences on a flow record for 5 days. This will be documented on a Behavior Flow Record and added to the 24 hour report by the charge nurse". The policy also documented that resident's receiving a psychoactive medication will be monitored through Psychotropic Drug Committee. Review of the June MAR revealed that there was not a behavior monitoring flow sheet. The June 2012 MAR documented Ativan prn was administered 5 times. For 3 out 5 of the administrations staff failed to describe how the resident was exhibiting anxiety. No side effect monitoring was noted. No care plan was established for this new onset of behavior requiring pharmological intervention. An interview on 6/29/12 at 2:40 PM with nurse E14 (LPN) revealed that R178 expresses anxiety by trying to get up, being aggressive and combative. An interview with E3 (ADON) on 7/2/12 at 4 PM confirmed that there was no care plan and no behavior monitoring for R178 when anxiety and the use of a psychoactive medication was initiated.	F 329	4.) (a). The Director of Nursing or designee will perform random weekly audits to evaluate whether flow records are initiated upon the onset of a new behavior. (b).The Director of Nursing or designee will perform random weekly audits of behavior intervention monthly flow records to evaluate whether this flow record has been initiated with Psychotropic Medication. (c). The results of the audit will be forwarded to the Quality Assessment and Assurance Committee for their review. The Quality Assessment and Assurance Committee will determine the need for further audits and or action plans. 9/18/12	
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME	F 368		

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F 368	Continued From page 50 Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documents it was determined that the facility failed to ensure that resident group approval was obtained and a nourishing snack was available when dinner and breakfast were scheduled 15 hours apart. Findings include: Review of the meal service times revealed that dinner meals were delivered to the Holly unit at 4:30 PM and 4:45 PM and the Scott unit at 4:40 PM, 5:05 PM and 5:15 PM. The breakfast meals were delivered to Holly at 7:20 AM and 7:40 AM and Scott Unit at 7:30 AM, 7:50 AM and 8:10 AM. These meal delivery times allowed for 15 hours between dinner and breakfast.	F 368	1.) Meal service times on the Holly and the Scot Unit were changes so that the meal delivery times allows for 14 hours between dinner and breakfast. 2.) All Residents are at risk for this deficient practice. 3.) The Food Service Director or designee will in-service the kitchen staff on the new delivery times. 4.) (a). The Food Service Director or designee will perform random weekly observations to evaluate the meal delivery times. The results of the observation audit will be forwarded to the Quality Assessment and Assurance Committee for their review. The Quality Assessment and Assurance Committee will determine the need for further audits and or action plans. 9/18/12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085048	A. BUILDING _____ B. WING _____	07/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION CAPITOL	1225 WALKER ROAD DOVER, DE 19901

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F 368	Continued From page 51 On 6/26/12 an interview with the E17 (Food Service Director) revealed that there was a 15 hour gap between meals for the Scott and Holly unit residents, a nourishing snack was not available for residents other then those on prescribed evening snacks and she unaware of whether or not the resident group had approved the meals times. The snacks available on the units included single serve bags of cookies and crackers. An interview on 6/29/12 at 4 PM with the E1 (administrator) confirmed that there was no resident approval of the meal times and a nourishing snack was not available for all residents. E1, however, provided a resident council meeting summary dated 6/27/12 in which the residents approved the 15 hours between meals. He confirmed that the snack selection would be reviewed and modified to allow for a nourishing evening snack.	F 368		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by:	F 428		

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F 428	Continued From page 52 Based on record review and interview the facility, failed to ensure a recommendation by the pharmacy consultant was reviewed and acted upon by the physician for one (R95) out of 40 sampled residents. Findings include: Review of R95's medication regimen review (MRR) dated 5/30/12 documented a recommendation for weekly blood pressure (BP) checks. A written copy dated 5/31/12 was sent to the facility. Review of R95's monthly orders signed 6/5/12 and subsequent physician order sheets through 7/2/12 lacked evidence of response to the 5/30/12 MRR recommendation. An interview with E26 (LPN) on 7/3/12 at 9:00 AM acknowledged lack of response to BP monitoring after reviewing the chart. The consultant's recommendation was located in the physician's box unsigned. E26 immediately contacted the physician and obtained a verbal order. Findings were reviewed with E2 (DON) on 7/3/12 at 9:35 AM.	F 428	1.) Resident # 95's medication regimen review request for weekly blood pressures is being done. . 2.) Residents receiving medication regime reviews of their Medication Administration Records are at risk for this deficient practice. 3.) (a) Medication regimen review recommendations are forwarded to the appropriate Physicians for their review and their/acknowledgement of the pharmacy recommendation. 4.) (a). Results of the Medication Regimen Review pertaining to the Physician's acknowledgment will be audited monthly to evaluate whether the recommendations have been signed. (b).The results of these audits will be forwarded to the Quality Assessment and Assurance Committee. The Quality Assessment and Assurance Committee will determine the need for further audits and or action plans. 9/18/12	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441		

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F 441	Continued From page 53 in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, review of other facility documentation, and staff interviews, it was determined that the facility failed to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The facility failed to document and trend infections within the facility	F 441	1.) (a). The facility's infection control program documentation from May 2012 through June 2012 is completed identifying the type organism. (b). R 226 no longer resides at the center (c). E 18 has been in-serviced proper hand washing techniques when administering transdermal patches and eye drops. 2.) All Resident's with infections and with C-Diff have the potential to be affected by this deficient practice. All Residents who have transdermal patches and eye drops administered are at risk for this deficient practice. 3.) (a).The Assistance Director of Nursing or designee will maintain the infection control log which identifies the type of organism (b) Resident's with positive stool cultures for C-Diff will be isolated (c). The Staff Developer or designee will in-service the Licensed Nursing Staff on the proper guidelines for hand washing during medication administration of tansdermal patches and eye drops.	

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F 441	Continued From page 54 from May 2012 through June 2012. The facility failed to ensure that R226 was isolated to prevent the spread of infections. The facility failed to ensure proper infection control techniques were used during a medication administration. Findings include: 1. Review of the facility infection control program documentation from May 2012 through June 2012 revealed that facility failed to identify the type of organisms infecting residents. This failure prevented the facility from trending the organisms to determine if there was a pattern of infection that the facility needed to address. Review of the facility's data also noted that infections were at times either not included on the line listing or inaccurate information was entered on the line listing of infections. 2. Review of R226's stool culture results dated 6/25/12 documented a positive result for clostridium difficile. An interview with the E19 (nurse) on 7/3/12 at 9 AM revealed that R226 was not isolation. An interview with E3 (ADON) on 7/3/12 at approximately 10 AM confirmed that R226 should be on isolation. 3. During medication pass on 6/26/12 at 9 AM E18 (LPN) was at the medication cart preparing medication. She entered R238's room and donned gloves. No handwashing was observed. E18 opened and handed R238 an Emsam 6 mg/24 hour patch to put on the abdomen. E18 then removed her gloves and donned new gloves	F 441	4.) (a).The Director of Nursing or designee will audit the "monthly" infection control log weekly to evaluate whether it is up to date.(b). The Assistance Director of Nursing or designee will review stool specimens for C-Diff to evaluate whether the Resident is isolated (c). The Staff Developer or designee will perform random weekly medication administration passes to evaluate whether the licensed nurse is washing hands and donning gloves appropriately. (d). The results of these audits will be forwarded to the QA &A Committee for their review. The QA &A Committee will determine the need for further audits and action plans. 9/19/12	

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F 441	Continued From page 55 without washing her hands. E18 then proceeded to administer Restasis eye drops in both R238's eyes. E18 did wash her hands as she left the residents room. An interview with E18 on 7/2/12 confirmed that after preparing the medication and assisting the resident with her patch she did not wash her hands before administering eye drops.	F 441		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Cadia Rehabilitation – Capitol

DATE SURVEY COMPLETED: July 3, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual survey was conducted at this facility from June 26. 2012 through July 3, 2012. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 111. The Stage 2 sample totaled 40 residents.	
3201	**Regulations for Skilled and Intermediate Care Facilities**	
3201.1	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report dated 7/3/12, F241, F247, F278, F279, F280, F309, F315, F325, F329, F334, F368, F428, & F441.	Cross reference plan of correction for CMS report dated July 3, 2012 F241, F247, F278, F279, F280, F309, F315, F325, F329, F334, F368, F428 & F441 9/18/2012

Provider's Signature _____ Title Administrator Date 8/3/12